STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00193288 and IN00193652. Complaint IN00193288 - Substantiated. Federal/State deficiencies are cited at F157, F282, F323 and F309. Complaint IN00193652 - Substantiated. Federal/State deficiencies are cited at F157, F282, F323 and F309. Survey dates: February 16, 17 and 18, 2016. Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census bed type: SNF: 14 SNF/NF: 166 Total:180 Census payor type: Medicare: 8 Medicaid: 127 Other: 45 Total: 180 These deficiencies reflect State findings	F 0000	Please accept this Plan of Correction as our facility's Credible Allegation of compliance for our Recertification and State Licensure Survey concluded on February 18, 2016. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This plan of correction is being submitted solely because doing so is required by state and federal law. Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised or implemented as part of this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on February 25, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of			

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	the resident's legal representative or interested family member. Based on record review and interview, the facility failed to provide timely physician and power of attorney notification for a resident who had sustained a fall that resulted in a femur fracture and required hospitalization and lower leg amputation for one of three residents reviewed for accidents. (Resident B) Finding includes: On 2/16/16 at 1:00 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 3/30/11. Diagnoses included but were not limited to, Alzheimer's disease, muscle weakness generalized, pulmonary heart disease and chronic obstructive pulmonary disease. An annual Minimum Data Set (MDS) assessment, reference date of 12/5/15, indicated Resident B required extensive assist of 2 people for transfers and did not ambulate. The MDS assessment further indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. A care plan, created on 03/30/15,	F 0157	**F 157 NOTIFY OF CHANGES(INJURY/DECLINE/ROOM, ETC)** This facility will immediately inform the resident; consult with the resident's physician; and if known,notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);or a decision to transfer or discharge the resident from the facility. This facility will also promptly notify the resident and the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in483.15(e)(2); or a change in resident rights under Federal or State law or regulationsas specified in paragraph (b)(1) of this section. The facility will record and periodically update the address and phone number of the resident's legal representative or	03/17/2016

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	indicated, but was not limited to, "... At risk for falls r/t [related to] high risk medication use, impaired memory, incontinence, and inability to stand... Interventions/Tasks... Hoyer Lift for transfers with 2 assist...Date Initiated: 05/05/13...." A resident care guide, dated 1/19/16, indicated "...[Resident B] Transfer Assist H [Hoyer lift]...." A nursing progress note, dated 1/20/16 at 01:09 A.M., indicated "... Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen. Resident received scheduled dose of acetaminophen [a pain medication]. MD [medical doctor] notified and received order for x-ray to left knee. POA [power of attorney] notified. Confirmed displacement. MD ordered transfer to ER [emergency room]. Resident sent to [name of local hospital]. Report called into [name of local hospital] ER...." A "Fall Scene Investigation Report" indicated "... Date of Fall: 1/19/16...Time of Fall: 3:30 PM...Staff witness present...Fall Summary: Fall to the floor (witnessed)... Fall Location: Resident room...What was resident doing during or just prior to fall: Transfer assisted by staff... What type of assistance was		interested family member. **Corrective Action:** Upon observing edema in resident B's left knee, LPN2 notified the physician and the resident's POA of the change of condition on1/19/16 at 7:45pm. RN #1 received disciplinary action for failure to notify the physician and guardian on 1/19/16at 3:30pm after the incident occurred. She completed applicable education prior to returning to work. **Howothers are identified:** All residents have the potential to be affected by this alleged deficient practice. **PreventativeMeasures**: Licensed nurses were educated on notification of changes. The 24 hour report sheet was revised to encompass this information and will be reviewed by staff at every change of shift. **Monitoring:** Conditions requiring physician, resident and legal representative or interested family member notification will be audited by the Director of Nursing/Designee. This audit will review resident changes and notification 5x weekly for the first month, 3x weekly for 3 months and 2x weekly for two months. Results of this audit will be presented to QAPI for need for further monitoring. **Date of Completion:** March 17, 2016.	

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	resident receiving at time of fall: Assisted less than per care plan...What appears to be the root cause of the fall? CNA [Certified Nursing Assistant] did not use correct mode to transfer resident...Signature [Registered Nurse #1]...Date and Time: 1/19/16...." A " Fall" report, dated 1/19/16 at 19:45 (7:45 P.M.), indicated "...Incident Location: Resident's room...Person Preparing Report: [Licensed Practical Nurse #2]... Nursing description: Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen... Immediate Action Taken: Resident received scheduled dose of Acetaminophen. MD notified and received order for xray to left knee. POA notified. Confirmed displacement. Resident sent to [name of local hospital]...Injury type: unable to determine... Level of Pain: PAINAD [sic]: 6...Negative Vocalization:1...Occasional Moan or Groan...Facial Expression: 2... Facial Grimacing...Body Language: 2...Rigid, Fists Clenched, Knees Pulled Up, Pulling or Pushing Away, Striking Out... Consolability:1...Distracted or Reassured by Voice or Touch...Mental Status: Oriented to Person...Predisposing Situation Factors: Other...During Transfer[sic]...Witnesses: [name of			

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	CNA] Relation: Staff...Date: 1/19/2016...Statement: " I was getting resident up for dinner and transferred resident by myself with gait belt. She started sitting down during turn and fell on floor with legs bent. I notified nurse in charge of resident [name of #Licensed Practical Nurse #1]...Agencies/People notified: Family Member [name] 1/19/2016 20:12 [8:12 P.M.]...Physician [name] 1/19/2016 19:50 [7:50 P.M.]...." A Radiology report, dated 1/19/16, indicated "... Conclusion: Acute distal femur displaced fracture...." A [name of local hospital] consultation report, dated 1/20/16, indicated "... 81 year old who has been immobile for the last year had an accident at the nursing home fracturing her supracondylar femur. She was evaluated by [name of physician] orthopedics and between her dementia and immobility and brittle bones her rehabilitation potential was essentially 0. After discussing with her caregiver decision was made for an amputation. The patient apparently does not speak...." On 2/17/16 at 10:15 A.M., an interview was conducted with RN (Registered Nurse) #1. RN #1 indicated she had been notified by CNA #1 around 3:30 P.M. on			

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	1/19/16, of a fall that had occurred during a transfer. Resident B was sitting in her wheelchair upon entry to her room. RN #1 indicated she did an assessment, neuro checks, vitals and range of motion and found nothing abnormal at the time. She further indicated she did not document her assessment in the resident's clinical record or notify the physician and power of attorney of the fall nor did she report the fall to the oncoming nurse at the end of her shift. RN #1 indicated "...I was busy at that time, I know it's a poor excuse but it's true...." RN #1 further indicated she should have notified the unit manager, physician, power of attorney, start an incident report and reassess the resident...." On 2/17/16 at 11:00 A.M., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 indicated that on the evening of 1/19/16 around 7:30 P.M., she was requested by CNA #1 to come to Resident B's room to assess her knee, CNA #1 indicated it was swollen and laid [position] funny. LPN #2 indicated that upon assessment she found Resident B's knee to be swollen and displaced but she could not determine at the time how far up the displacement went because Resident B was still wearing her pants and was sitting in a wheelchair. She indicated she			

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	then notified the Nurse Practitioner, the Power of Attorney and the Director of Nurses. On 2/16/16 at 1:00 P.M., the Director of Nurses provided the policy, "Assessing Falls and Their Causes," revision date October 2010, and indicated it was one currently used by the facility. The policy indicated "....4. Notification of the physician and family as indicated...." This Federal tag relates to Complaints IN00193288 and IN00193652. 3.1-5(a)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on record review and interview, the facility failed to ensure a resident was transferred according to the plan of care to prevent an accident that resulted in a femur fracture that required hospitalization and lower leg amputation for one of three residents reviewed for accidents. (Resident B) Finding includes: On 2/16/16 at 1:00 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 3/30/11. Diagnoses included but were not limited to, Alzheimer's disease, muscle weakness generalized, pulmonary heart disease and chronic obstructive pulmonary disease unspecified. An annual Minimum Data Set (MDS) assessment, reference date of 12/5/15, indicated Resident B required extensive assist of 2 people for transfers and did not ambulate. The MDS assessment indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. A care plan created on 03/30/15 indicated, but was not limited to, "... At risk for falls r/t [related to] high risk medication use, impaired memory, incontinence, and inability to stand...	F 0282	**F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Services provided or arranged by this facility will be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** Resident B is transferred per her written plan of care. CNA #1's employmentat this facility was terminated. **How others are identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures:** The CNA/Nurse new employee orientation check off was revised to include reading and interpreting the information included on the resident care guides. A new policy and procedure was developed to define the development and maintenance of the care guide. Nursing staff was re-educated and tested on following the plan of care. **Monitoring:** The Director of Nursing/Designee will complete random audits on nursing staff following the plan of care 5x weekly for the first month, 3x weekly for 3 months and 2x weekly for two months. Results of this audit will be presented to QAPI for need for further monitoring. **Date of Completion:** March 17, 2016.	03/17/2016

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	Interventions/Tasks... Hoyer Lift for transfers with 2 assist...Date Initiated: 05/05/13...." A resident care guide, dated 1/19/16, indicated "...[Resident B] Transfer Assist H [Hoyer lift]...." A nursing progress note, dated 1/20/16 at 01:09 A.M., indicated "... Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen. Resident received scheduled dose of acetaminophen [a pain medication]. MD [medical doctor] notified and received order for x-ray to left knee. POA [power of attorney] notified. Confirmed displacement. MD ordered transfer to ER [emergency room]. Resident sent to [name of local hospital]. Report called into [name of local hospital] ER...." A "Fall Scene Investigation Report" indicated "... Date of Fall: 1/19/16...Time of Fall: 3:30 PM...Staff witness present...Fall Summary: Fall to the floor (witnessed)... Fall Location: Resident room...What was resident doing during or just prior to fall: Transfer assisted by staff... What type of assistance was resident receiving at time of fall: Assisted less than per care plan...What appears to be the root cause of the fall? CNA [Certified Nursing Assistant] did not use			

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	correct mode to transfer resident...Signature [Registered Nurse #1]...Date and Time: 1/19/16...." A "Fall" report, dated 1/19/16 at 19:45 (7:45 P.M.), indicated "...Incident Location: Resident's room...Person Preparing Report: [Licensed Practical Nurse #2]... Nursing description: Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen... Immediate Action Taken: Resident received scheduled dose of Acetaminophen. MD notified and received order for x-ray to left knee. POA notified. Confirmed displacement. Resident sent to [name of local hospital]...Injury type: unable to determine... Level of Pain: PAINAD [sic]: 6...Negative Vocalization:1...Occasional Moan or Groan...Facial Expression: 2... Facial Grimacing...Body Language: 2...Rigid, Fists Clenched, Knees Pulled Up, Pulling or Pushing Away, Striking Out... Consolability:1...Distracted or Reassured by Voice or Touch...Mental Status: Oriented to Person...Predisposing Situation Factors: Other...During Transfer[sic]...Witnesses: [name of CNA] Relation: Staff...Date: 1/19/2016...Statement: " I was getting resident up for dinner and transferred resident by myself with gait belt. She			

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	started sitting down during turn and fell on floor with legs bent. I notified nurse in charge of resident [name of #Licensed Practical Nurse #1]...Agencies/People notified: Family Member [name] 1/19/2016 20:12 [8:12 P.M.]...Physician [name] 1/19/2016 19:50 [7:50 P.M.]...." A Radiology report, dated 1/19/16, indicated "... Conclusion: Acute distal femur displaced fracture...." A [name of local hospital] consultation report, dated 1/20/16, indicated "... 81 year old who has been immobile for the last year had an accident at the nursing home fracturing her supracondylar femur. She was evaluated by [name of physician] orthopedics and between her dementia and immobility and brittle bones her rehabilitation potential was essentially 0. After discussing with her caregiver decision was made for an amputation. The patient apparently does not speak...." On 2/17/16 at 10:15 A.M., an interview was conducted with RN (Registered Nurse) #1. RN #1 indicated she had been notified by CNA #1 around 3:30 P.M. on 1/19/16, of a fall that had occurred during a transfer. Resident B was sitting in her wheelchair upon entry to her room. RN #1 indicated she did an assessment, neuro			

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	checks, vitals and range of motion and found nothing abnormal at the time. She further indicated she did not document her assessment in the resident's clinical record or notify the physician and power of attorney of the fall nor did she report the fall to the oncoming nurse at the end of her shift. RN #1 indicated "...I was busy at that time, I know it's a poor excuse but it's true...." On 2/17/16 at 11:00 A.M., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 indicated that on the evening of 1/19/16 around 7:30 P.M., she was requested by CNA #1 to come to Resident B's room to assess her knee, CNA #1 indicated it was swollen and laid funny. LPN #2 indicated that upon assessment she found Resident B's knee to be swollen and displaced but she could not determine at the time how far up the displacement went because Resident B was still wearing her pants and was sitting in a wheelchair. She indicated she then notified the Nurse Practitioner, the Power of Attorney and the Director of Nurses. On 2/17/16 at 9:00 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated that CNA#1 had completed the facilities nurse aide training course and was			

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	educated on how to perform a Hoyer lift transfer. She further indicated CNA #1 was released from her employment at the facility for improperly transferring Resident B. This Federal tag relates to Complaints IN00193288 and IN00193652. 3.1-35(g)(2)			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			

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	155689	A. BUILDING 00 B. WING	02/18/2016

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COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the facility failed to ensure staff completed an adequate assessment and provide timely services for a resident who had sustained a fall that resulted in a femur fracture and required hospitalization and lower leg amputation for one of three residents reviewed for accidents. (Resident B) Finding includes: On 2/16/16 at 1:00 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 3/30/11. Diagnoses included but were not limited to, Alzheimer's disease, muscle weakness generalized, pulmonary heart disease and chronic obstructive pulmonary disease. An annual Minimum Data Set (MDS) assessment, reference date of 12/5/15, indicated Resident B required extensive assist of 2 people for transfers and did not ambulate. The MDS assessment indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. A care plan, created on 03/30/15, indicated, but was not limited to, "... At risk for falls r/t [related to] high risk medication use, impaired memory,	F 0309	**F 309 PROVIDE CARE/SERVICESFOR HIGHEST WELL BEING** This facility will provide our residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Corrective Action:** Resident B received a comprehensive assessment after returning from the hospital on 1/23/16 and her plan of care was revised. Resident B receives the necessary care and services to maintain her highest practicable physical, mental, and psychosocial well-being. **How others are identified:** All residents have the potential to be affected by this alleged deficient practice. **Preventative Measures**: Licensed nurses were educated on post fall procedure including assessment, notification to physician for timely services, notification to interested family or legal representative, and timely documentation in the clinical record. The fall incident report was revised to adequately capture all the assessment findings. The CNAs were educated on the importance of not moving the resident prior to the licensed nurse completing an assessment. **Monitoring:** The Director of Nursing/Designee will audit post fall documentation for complete assessments,	03/17/2016

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	incontinence, and inability to stand... Interventions/Tasks... Hoyer Lift for transfers with 2 assist...Date Initiated: 05/05/13...." A resident care guide, dated 1/19/16, indicated "...[Resident B] Transfer Assist H [Hoyer lift]...." A nursing progress note, dated 1/20/16 at 01:09 A.M., indicated "... Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen. Resident received scheduled dose of acetaminophen [a pain medication]. MD [medical doctor] notified and received order for x-ray to left knee. POA [power of attorney] notified. Confirmed displacement. MD ordered transfer to ER [emergency room]. Resident sent to [name of local hospital]. Report called into [name of local hospital] ER...." A "Fall Scene Investigation Report" indicated "... Date of Fall: 1/19/16...Time of Fall: 3:30 PM...Staff witness present...Fall Summary: Fall to the floor (witnessed)... Fall Location: Resident room...What was resident doing during or just prior to fall: Transfer assisted by staff... What type of assistance was resident receiving at time of fall: Assisted less than per care plan...What appears to be the root cause of the fall? CNA		subsequent services, and physician notification. This audit will become a facility practice. In addition the Director of Nursing/Designee will observe licensed nurses conduct assessments post fall when the occurrence happens and nurse management staff is present in the facility. This audit will continue for 6 months and results of this audit will be presented to QAPI for need for further monitoring. **Date of Completion:** March 17, 2016.	

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	[Certified Nursing Assistant] did not use correct mode to transfer resident...Signature [Registered Nurse #1]...Date and Time: 1/19/16...." A "Fall" report, dated 1/19/16 at 19:45 (7:45 P.M.), indicated "...Incident Location: Resident's room...Person Preparing Report: [Licensed Practical Nurse #2]... Nursing description: Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen... Immediate Action Taken: Resident received scheduled dose of Acetaminophen. MD notified and received order for x-ray to left knee. POA notified. Confirmed displacement. Resident sent to [name of local hospital]...Injury type: unable to determine... Level of Pain: PAINAD [sic]: 6...Negative Vocalization:1...Occasional Moan or Groan...Facial Expression: 2... Facial Grimacing...Body Language: 2...Rigid, Fists Clenched, Knees Pulled Up, Pulling or Pushing Away, Striking Out... Consolability:1...Distracted or Reassured by Voice or Touch...Mental Status: Oriented to Person...Predisposing Situation Factors: Other...During Transfer[sic]...Witnesses: [name of CNA] Relation: Staff...Date: 1/19/2016...Statement: " I was getting resident up for dinner and transferred			

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	resident by myself with gait belt. She started sitting down during turn and fell on floor with legs bent. I notified nurse in charge of resident [name of #Licensed Practical Nurse #1]...Agencies/People notified: Family Member [name] 1/19/2016 20:12 [8:12 P.M.]...Physician [name] 1/19/2016 19:50 [7:50 P.M.]...." A Radiology report, dated 1/19/16, indicated "... Conclusion: Acute distal femur displaced fracture...." A [name of local hospital] consultation report, dated 1/20/16, indicated "... 81 year old who has been immobile for the last year had an accident at the nursing home fracturing her supracondylar femur. She was evaluated by [name of physician] orthopedics and between her dementia and immobility and brittle bones her rehabilitation potential was essentially 0. After discussing with her caregiver decision was made for an amputation. The patient apparently does not speak...." On 2/17/16 at 10:15 A.M., an interview was conducted with RN [Registered Nurse] #1. RN #1 indicated she had been notified by CNA #1 around 3:30 P.M. on 1/19/16, of a fall that had occurred during a transfer. Resident B was sitting in her wheelchair upon entry to her room. RN			

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	#1 indicated she did an assessment, neuro checks, vitals and range of motion and found nothing abnormal at the time. She further indicated she did not document her assessment in the resident's clinical record or notify the physician and power of attorney of the fall nor did she report the fall to the oncoming nurse at the end of her shift. RN #1 indicated "...I was busy at that time, I know it's a poor excuse but it's true...." RN #1 further indicated she should have notified the unit manager, physician, power of attorney, start an incident report and reassess the resident...." On 2/17/16 at 11:00 A.M., an interview was conducted with LPN [Licensed Practical Nurse] #2. LPN #2 indicated that on the evening of 1/19/16 around 7:30 P.M., she was requested by CNA #1 to come to Resident B's room to assess her knee, CNA #1 indicated it was swollen and laid funny. LPN #2 indicated that upon assessment she found Resident B's knee to be swollen and displaced but she could not determine at the time how far up the displacement went because Resident B was still wearing her pants and was sitting in a wheelchair. On 2/16/16 at 1:00 P.M., the Director of Nurses provided the policy, "Assessing Falls and Their Causes," revision date			

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	October 2010, and indicated it was one currently used by the facility. The policy indicated "... Steps in the Procedure...After a Fall: 3. Once an assessment rules out significant injury , nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details...Documentation...When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g. " resident found lying on the floor between bed and chair")...2. Assessment data, including vital signs and any obvious injuries...3. Interventions, first aid, or treatment administered...4. Notification of the physician and family, as indicated...." This Federal tag relates to Complaints IN00193288 and IN00193652. 3.1-37(a)			

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F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide adequate assistance during a transfer to prevent an accident that resulted in a femur fracture that required hospitalization and lower leg amputation for one of three residents reviewed for accidents. (Resident B) Finding includes: On 2/16/16 at 1:00 P.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 3/30/11. Diagnoses included but were not limited to, Alzheimer's disease, muscle weakness generalized, pulmonary heart disease and chronic obstructive pulmonary disease. An annual Minimum Data Set (MDS) assessment, reference date of 12/5/15,	F 0323	**F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES** This facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** Resident B receives transfers with the assistance of two staff members and a mechanical lift. Resident B remains free of accidents and has had no further falls. **Preventative Measures:** The CNA/Nurse new employee orientation check off was revised to include reading and interpreting the information included on the resident care guides to ensure adequate assistance is provided during a resident transfer. Nursing employees were re-educated on transfer technique and checked	03/17/2016

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	indicated Resident B required extensive assist of 2 people for transfers and did not ambulate. The MDS assessment indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. A care plan, created on 03/30/15, indicated, but was not limited to, "... At risk for falls r/t [related to] high risk medication use, impaired memory, incontinence, and inability to stand... Interventions/Tasks... Hoyer Lift for transfers with 2 assist...Date Initiated: 05/05/13...." A resident care guide, dated 1/19/16, indicated "...[Resident B] Transfer Assist H [Hoyer lift]...." A nursing progress note, dated 1/20/16 at 01:09 A.M., indicated "... Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen. Resident received scheduled dose of acetaminophen [a pain medication]. MD [medical doctor] notified and received order for x-ray to left knee. POA [power of attorney] notified. Confirmed displacement. MD ordered transfer to ER [emergency room]. Resident sent to [name of local hospital]. Report called into [name of local hospital] ER...."		off using return demonstration. Additional education included post fall procedures directing CNAs to refrain from moving the resident until a licensed nurse has completed an assessment. **Monitoring:** The Director of Nursing/Designee will complete random audits on nursing staff completing transfers using adequate assistance as indicated in the plan of care 5x weekly for the first month, 3x weekly for 3 months and 2x weekly for two months. Results of this audit will be presented to QAPI for need for further monitoring. **Date of Completion:** March 17, 2016.	

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	A "Fall Scene Investigation Report" indicated "... Date of Fall: 1/19/16...Time of Fall: 3:30 PM...Staff witness present...Fall Summary: Fall to the floor (witnessed)... Fall Location: Resident room...What was resident doing during or just prior to fall: Transfer assisted by staff... What type of assistance was resident receiving at time of fall: Assisted less than per care plan...What appears to be the root cause of the fall? CNA [Certified Nursing Assistant] did not use correct mode to transfer resident...Signature [Registered Nurse #1]...Date and Time: 1/19/16...." A "Fall" report, dated 1/19/16 at 19:45 (7:45 P.M.), indicated "...Incident Location: Resident's room...Person Preparing Report: [Licensed Practical Nurse #2]... Nursing description: Nurse called to room to assess edema noted to Left knee. Left knee confirmed swollen... Immediate Action Taken: Resident received scheduled dose of Acetaminophen. MD notified and received order for x-ray to left knee. POA notified. Confirmed displacement. Resident sent to [name of local hospital]...Injury type: unable to determine... Level of Pain: PAINAD [sic]: 6...Negative Vocalization:1...Occasional Moan or Groan...Facial Expression: 2... Facial			

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	Grimacing...Body Language: 2...Rigid, Fists Clenched, Knees Pulled Up, Pulling or Pushing Away, Striking Out... Consolability:1...Distracted or Reassured by Voice or Touch...Mental Status: Oriented to Person...Predisposing Situation Factors: Other...During Transfer[sic]...Witnesses: [name of CNA] Relation: Staff...Date: 1/19/2016...Statement: " I was getting resident up for dinner and transferred resident by myself with gait belt. She started sitting down during turn and fell on floor with legs bent. I notified nurse in charge of resident [name of #Licensed Practical Nurse #1]...Agencies/People notified: Family Member [name] 1/19/2016 20:12 [8:12 P.M.]...Physician [name] 1/19/2016 19:50 [7:50 P.M.]...." A Radiology report, dated 1/19/16, indicated "... Conclusion: Acute distal femur displaced fracture...." A [name of local hospital] consultation report, dated 1/20/16, indicated "... 81 year old who has been immobile for the last year had an accident at the nursing home fracturing her supracondylar femur. She was evaluated by [name of physician] orthopedics and between her dementia and immobility and brittle bones her rehabilitation potential was essentially 0. After discussing with her			

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	caregiver decision was made for an amputation. The patient apparently does not speak...." On 2/17/16 at 10:15 A.M., an interview was conducted with RN (Registered Nurse) #1. RN #1 indicated she had been notified by CNA #1 around 3:30 P.M. on 1/19/16, of a fall that had occurred during a transfer. Resident B was sitting in her wheelchair upon entry to her room. RN #1 indicated she did an assessment, neuro checks, vitals and range of motion and found nothing abnormal at the time. She further indicated she did not document her assessment in the resident's clinical record or notify the physician and power of attorney of the fall nor did she report the fall to the oncoming nurse at the end of her shift. RN #1 indicated "...I was busy at that time, I know it's a poor excuse but it's true...." RN #1 further indicated she should have notified the unit manager, physician, power of attorney, start an incident report and reassess the resident...." On 2/17/16 at 11:00 A.M., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 indicated that on the evening of 1/19/16 around 7:30 P.M., she was requested by CNA #1 to come to Resident B's room to assess her knee, CNA #1 indicated it was			

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	swollen and laid funny. LPN #2 indicated that upon assessment she found Resident B's knee to be swollen and displaced but she could not determine at the time how far up the displacement went because Resident B was still wearing her pants and was sitting in a wheelchair. She indicated she then notified the Nurse Practitioner, the Power of Attorney and the Director of Nurses. On 2/17/16 at 9:00 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated that CNA#1 had completed the facilities nurse aide training course and was educated on how to perform a Hoyer lift transfer. She further indicated CNA #1 was released from her employment at the facility for improperly transferring Resident B. On 2/16/16 at 1:00 P.M., the Director of Nurses provided the policy, "Assessing Falls and Their Causes," revision date October 2010, and indicated it was one currently used by the facility. The policy indicated "... Steps in the Procedure...After a Fall: 3. Once an assessment rules out significant injury , nursing staff will help the resident to a comfortable sitting, lying, or standing position, and then document relevant details...Documentation...When a			

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	resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g. " resident found lying on the floor between bed and chair")...2. Assessment data, including vital signs and any obvious injuries...3. Interventions, first aid, or treatment administered...4. Notification of the physician and family, as indicated...5. Completion of a falls risk assessment...6. Appropriate interventions taken to prevent future falls...7. The signature and title of the person recording the data...." This Federal tag relates to Complaints IN00193288 and IN00193652. 3.1-45(a)(1)			